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Developing an adult safeguarding outcome measure in England

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Review

Developing an adult safeguarding outcome measure in England

Background

Protecting adults at risk from neglect or abuse is referred to as adult safeguarding in England. Local Authorities (LAs) have lead responsibility for conducting adult safeguarding investigations following the raising of concerns about the safety of adults at risk (a former term being ‘vulnerable adults’). Many allegations or suspicions, however, are investigated collaboratively, for example, by healthcare professionals, police officers and social workers.

Feedback from adults at risk who have been involved in a safeguarding investigation is currently not collected systematically and their involvement in service design has been described as limited (Cambridge et al., 2011, Graham et al., 2014, Fyson and Kitson, 2012). This is despite substantial data collection being undertaken at LA level about the processes of adult safeguarding (Fyson, 2013). There is therefore little knowledge about whether adults at risk are satisfied with the support they receive during a safeguarding investigation, and little data which can be used to compare outcomes with other LAs or inform quality assurance activities. This has implications for benchmarking and resource allocation (Fyson, 2013, Fyson and Kitson, 2012).

The lack of involvement of adults at risk in recording the outcomes from safeguarding investigations has been attributed to their vulnerability or frailty and to fears that LA

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3 requests for feedback might cause further harm by revisiting times of distress. However,
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5 given the general move towards personalisation and person-centred practice in health and
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7 social care over the last decade, this lack of input is viewed as sub-optimal and LAs are
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9 increasingly keen to measure their performance with data from end users (see, for example,
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11 Northway et al., 2013).
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17 The adult safeguarding data currently collected by LAs, the Safeguarding Adults Return
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19 (SARs), was introduced in 2013/14. LAs report aggregate totals of various aspects of
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21 safeguarding work, such as details of the alleged victim, the alleged perpetrator and the
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23 location of the abuse. Data are submitted to the Health and Social Care Information Centre
24
25 (HSCIC). Previously the Abuse of Vulnerable Adults (AVA) returns had been in place since
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27 2010-11. Both the SAR and the AVA have been criticised as focusing on LA administrative
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29 processes and workloads rather than the perspectives of vulnerable adults (Fyson, 2013).
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36 The effectiveness of AVA returns and SAR data as a comparative indicator has also been
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38 questioned as the thresholds whereby someone is designated a 'safeguarding' case (rather
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40 than being allocated, for example, to routine care management) vary across locations
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42 (Cambridge and Parkes, 2004, Thacker, 2011). McCreadie et al. (2008) described the 'elastic
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44 phenomenon' of thresholds varying within and across different LAs as a result of ill-defined
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46 terminology, which is dependent on 'individual decision-making' and 'agency priorities'.
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52 Indeed, overall there is a '*severe lack of evidence on the efficacy of safeguarding*
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54 *interventions*' (Sutcliffe et al., 2012). This concern has been highlighted in the context of the
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greater policy interest in adult safeguarding over the past few years which has included the Review of the multi-agency safeguarding guidance, *No Secrets* (Department of Health and Home Office, 2000) the government response to this Review (Department of Health, 2009), proposals for legal reform (Law Commission, 2012), the passing of the Mental Capacity Act 2005 (which includes measures criminalising ill-treatment and wilful neglect) (Manthorpe and Samsi, 2014), policy to reform adult social care (Department of Health, 2012) as well as reports on a series of high profile scandals, such as the Francis Report (Francis, 2013). The Care Act 2014 (The Care Act, 2014a) codified adult safeguarding practices in statute and the Care Act 2014 Statutory Guidance has modified elements related to adult safeguarding following public consultation (The Care Act, 2014b).

Against this background of policy interest in adult safeguarding, the Department of Health has supported efforts to improve outcomes in adult safeguarding under the Making Safeguarding Personal (MSP) sector-led improvement programme. MSP activity aims to facilitate a shift in LA emphasis from processes to improving outcomes for people at risk of harm (Manthorpe et al., 2014). Its focus is on enhancing practitioner understanding of what people wish to achieve, recording their desired outcomes, developing effective responses, and assessing their effectiveness.

Concurrently, the Outcomes and Information Development Board (OIDB), jointly chaired by the Department of Health (DH), ADASS (Association of Directors of Adult Social Services), the Care Quality Commission (CQC), and other relevant groups, including service user representatives, agreed that the development of a national measure of safeguarding

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3 outcomes was of high importance (Health and Social Care Information Centre, 2012) and
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5 should be included in the Adult Social Care Outcomes Framework (ASCOF). The HSCIC
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7 (previously the NHS Information Centre) is responsible for data collection and reporting at
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9 national and local levels in England. Among a multitude of tasks, it is responsible for
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11 administering and presenting the SAR data which feed into the most prominent social care
12
13 national level data in England - the ASCOF. Introduced in 2011-12 (Department of Health,
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15 2011) each LA in England is scored in the ASCOF on a range of measures which give an
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17 indication of service users' perspectives on the services they receive (Health and Social Care
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19 Information Centre, 2013). There are many measures that feed into the ASCOF data from
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21 different social care collections (Netten, 2011) and the two safeguarding questions are
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23 currently taken from a service user survey which is sent annually to a sample of those who
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25 receive LA support (Health and Social Care Information Centre, 2013). The two adult
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27 safeguarding related ASCOF measures are - *people who use services who say they feel safe*,
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29 and *people who use services who say services have made them feel safe and secure*. These
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31 measures are not targeted specifically at those who have undergone an adult safeguarding
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33 investigation and the survey may be impossible to complete by physically frail people or
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35 some adults at risk of abuse or neglect (Fyson, 2013).
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45 The HSCIC started in early 2014 to investigate the development of a measure to capture
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47 individuals' views about the outcomes of safeguarding investigations that had been carried
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49 out in response to specific concerns about adults at risk of abuse or neglect. If introduced,
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51 this would be a national survey, carried out in a face to face interview, and the information
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53 collected would feed into an ASCOT measure capturing how the enquiry or investigation
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process was experienced and how safe vulnerable adults feel themselves to be following the conclusion of investigations. This paper reports on the cognitive testing phase of developing this survey (if successful it was envisaged that future work would include piloting and carrying out an impact assessment of costs and benefits).

The aim of cognitively testing was to ascertain the suitability of the survey questions for adults at risk and their representatives. This study also aimed to collect LA staff views on the usability of the guidance designed to accompany the survey and the feasibility of administering the survey.

Methods

The initial stage of developing the survey was the formulation of the survey questions. This process included collecting examples of questions posed to adults at risk that were known to be used by some LAs as part of their own quality assurance processes (Klee and Williams, 2013). Discussions were then held with an expert stakeholder group to determine the survey questions and administrative procedures when conducting the survey. Decisions were made by members of the stakeholder group which was a partnership between the DH and Local Government Association, with representatives from the HSCIC, ADASS, and a research team from NatCen Social Research.

We decided to use the qualitative research method, cognitive testing, to assess possible survey questions for comprehensibility and consistency of understanding (Schwarz, 2007, Willis, 2005, Collins, 2015) and recruited an expert research organisation, NatCen to carry

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2
3 out fieldwork and analysis. The conceptual framework of cognitive testing is based on
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5 Tourangeau's (1984) four components of survey response (comprehension, retrieval,
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7 judgement and response).
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12 Cognitive testing involved asking participants to answer the survey questions and to then
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14 'think aloud' while researchers asked a second series of retrospective probing questions
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16 exploring participants' *understanding* and interpretations of the questions (including
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18 terminology); what information participants were thinking about and *retrieved* or recalled in
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20 order to answer the questions; how participants made *judgements* about what information
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22 to use when answering the questions; and how participants *responded* to the questions.
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29 The survey questions were designed to be answered by an adult at risk whose case had
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31 been through the alert, referral, investigation and conclusion stages of a safeguarding
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33 investigation. Where an adult at risk lacked decision making capacity or had died or was
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35 otherwise unable to participate, a relative/friend/carer or Independent Mental Capacity
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37 Advocate (IMCA) would be asked to participate, to give their own perspectives. (IMCAs are
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39 statutory advocates who are commissioned by LAs to support and represent people who
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41 lack the ability to make important decisions and have no-one to advocate for them (Social
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43 Care Institute for Excellence, 2009).) Survey questions were the same for all participants
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45 (apart from introductory paragraphs) and were designed to be asked verbatim as far as
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47 possible by adults at risk and by other participants (relatives/friends/carers and IMCAs).
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Three volunteer LAs were recruited. In each LA staff were asked to construct a purposive sample of 10 people from a range of age groups from their safeguarding database, to include, where possible, a range of people whose cases had been recorded as being from different safeguarding alert abuse categories (financial, physical, emotional, sexual, neglect). The overall aim was to interview 20 adults at risk (people for whom the safeguarding investigation had been concluded) and 10 relatives, friends, carers or IMCAs.

It was agreed that flexibility would be permitted about the types of cases in each LA and the demographic profile of cases. Once cases had been selected the LA officer (safeguarding manager or equivalent) decided on the basis of their professional judgment whether the invitation to participate in a face to face interview to administer the survey questions should be communicated to the individual adult at risk or a relative/friend/carers or IMCA. Paired interviews, where adults at risk wanted to be interviewed with a relative/friend/carers, would be permissible.

Where it was considered that a potential research participant (including those living in care or group homes) might be put at increased risk (or their confidentiality breached) by being sent an information sheet (e.g. they might live with the ‘perpetrator’), the LA was asked to identify and manage this risk, for example, by having a professional read out the information sheet over the telephone to the potential participant. Interviews took place in participants’ own homes and lasted between one to two hours and participants received a voucher to thank them for their contribution.

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3 The cognitive testing survey data were analysed by the researchers listening back to the
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5 interview recordings while completing a thematically structured matrix. This allowed
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7 systematic detailing and comparison of understandings of the question, information
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9 retrieved in answering the questions, judgements made in formulating an answer, question
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11 responses and any problems in answering the questions. The reliability of the answers was
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13 judged by the amount of variation in responses of participants (including across groups). The
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15 validity of the answers was judged by assessment of patterns of response between
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17 participants (including across groups). The emerging themes for each question were
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19 identified and this information was used to amend the survey (see appendix).
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26 Interviews and a focus group were carried out with members of staff in the different LAs
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28 who had been involved in the process of selecting and recruiting participants to assess the
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30 usability of the staff guidance document and the feasibility of the survey administration.
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32 These semi-structured interviews lasted around an hour and covered understanding of the
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34 staff guidance document and the ease of sampling and administrative issues. These
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36 interviews were analysed again using a qualitative approach where a thematic matrix was
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38 created in order to capture opinions on these three different elements, which were then
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40 sorted into themes and then used to inform changes to the guidance and administrative
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42 arrangements.
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50 Ethical approval was received for this study from the National Research Ethics Service
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52 (NRES) Social Care Research Ethics Committee (SCREC) (14/IEC08/0016). Research
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54 governance approval was also secured from the three participating LAs.
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Results

Overall results

Cognitive testing revealed that the survey questions were understood by the target participants but changes were needed to improve their reliability, validity and inter-comparability. The staff guidance needed revision for clarity and some sampling and administrative matters needed amending.

The Sample

Whether it was possible to recruit adults at risk and their relatives, friends, carers or IMCAs was a key question in this study. In the event, we interviewed 10 adults at risk and 20 relatives of adults at risk (rather than *our aim of 20 adults at risk, and 10 relatives/friends, carers/IMCAs*) (see Table 1). In six of the adult at risk interviews an additional person (relative, support worker or housing officer) was present to support the participant at their request. Of these interviews, four of the relatives or carers joined in making it a ‘paired interview’. Of the 10 adults at risk interviewed, seven had learning disabilities and we would describe three of the seven as having severe learning disabilities.

Insert Table 1 around here

No friends or IMCAs were initially interviewed because the three LAs did not supply details of these and indicated that they were both few in number in adult safeguarding cases. This under-recruitment of friends was not viewed as problematic as their views and demographics were regarded as probably similar to family members (whom we over

recruited). However, lack of IMCA perspectives was viewed as concerning as this meant that the perspectives of people lacking mental capacity were missing so we therefore interviewed 10 IMCAs (4 face-to-face and 6 telephone) from *outside* the original LAs.

Of the interviews with LA staff, three interviews were carried out in two LAs; in the other LA staff preferred to take part in a focus group (FG) (n=6) as the organisation of safeguarding personnel in this particular LA meant a larger group of staff had been involved in the survey administration.

It proved possible to recruit a cross-section of participants, including those whose cases might be expected to be highly sensitive, such as those involving sexual abuse.

The sampling window of four weeks (following the case conclusion) had to be extended to eight weeks in order to recruit sufficient participant numbers. Most (21) of the interviews were concluded within four weeks of the case being concluded and nine cases within eight weeks. Given that many participants had memory loss or had learning disabilities, there was a possibility participants might not be able to remember the investigation. However, the lapse of time since the case was concluded did not seem to influence the ease or difficulty with which participants recalled the investigation.

A key finding however was that researchers had concerns about the cognitive capacity to be interviewed of some of the potential participants selected by the LAs, such as whether they could understand the questions and recall their experiences. The cognitive testing also

revealed that relatives had very different levels of knowledge about the safeguarding investigation, despite being the key contact or informant about their family member according to the LA records. This range spanned relatives who were fully informed and may have raised the safeguarding alert, to those who knew nothing about any incident(s) or even that a safeguarding investigation had been conducted. For the latter group of relatives, being approached to be involved in a survey about an investigation of which they were unaware was sometimes distressing.

The Survey

The development of survey questions can be viewed in Appendix 1. Some of the terminology used in the survey proved inaccessible. The words ‘information’ and ‘outcomes’ were not easily understood and one participant stated that the word ‘outcomes’ was not translatable in British Sign Language. Some adults at risk found the survey questions very hard to answer. It was concluded that questions would need to be simplified to make them more accessible and understandable, for example the term ‘satisfied’ would need to be replaced with ‘happy’ throughout the survey (unless inappropriate). The costs of communication and translation support would need to be assessed in the survey piloting stage.

The word ‘safer’ (questions 5 and 6) was understood differently by the various participants. Some adults at risk retrieved or recalled feelings and thoughts about being safer in more literal or specific ways, for example, having a roof over your head, not participating in risky

behaviours, or knowing that it would be more difficult for someone to break into your home. Relatives were more likely to consider safety in the context of abuse and neglect:

I still have concerns that she is not completely safe. I was stuck deciding between the middle two (options in the survey) – quite a bit and not much safer because it fluctuates day to day...sometimes you think depending what staff are on, thatthings look good...and then you go in the next day and you have concerns. [S2, relative, N04]

The response choice ‘completely’ was regarded as too definite (it was often interpreted as ‘completely safe’ and ‘completely satisfied’). Several relatives said it would be difficult to pick that category as they felt the person they supported could never be *completely* safe. Some IMCAs talked about those they support being ‘physically safe’, but also the wider meaning of feeling emotionally safe, for example, if an adult at risk wanted to stay in their own home as they felt emotionally safer living there rather than in a care home. It was also thought important to capture perspectives of those participants who were not happy with the outcome of their case, but were ‘safer’; for example, one participant with learning disabilities who wanted continued access to abusive ‘friends’.

Some adult at risk participants questioned whether what they said would impact on their social care services or support. IMCAs highlighted that due to the small sample sizes, they might be identifiable to LA staff, despite the survey being conducted confidentially. There was a wide difference of views between IMCAs who were not concerned if they were

identifiable, *'the council know exactly what I think - that's my job,'* [IMCA 8] to those who were wary of being identified.

Staff guidance and survey administration

LA participants expressed concern about the length of the guidance for LAs and some thought that various sections were unnecessary or key information was buried within the document. However, others admitted they had only 'skim read' the guidance, had only selectively read 'important' sections, or not read it at all. Some staff observed that the term 'case concluded' was used differently by LAs. Another key finding was the need to ensure that interviewers were alert in any contact with a family member where the adult at risk (their relative) had died and this needed to be asked of the LAs.

Discussion

There has been extensive debate about the development and definition of 'outcomes' measurement in the last decade (Glendinning et al., 2008, Netten, 2011) to which this feasibility study contributes. Many commentators have welcomed outcomes measurement in adult safeguarding. This is seen as a way of moving from the management of processes to the acquisition of evidence for increasing the resourcing of adult safeguarding (Lawson et al., 2014). However, an outcome may be over reductionist by giving the impression that safety is one dimensional. In addition, there is a risk that outcomes measurement becomes part of an overbearing performativity culture which enables staff to be increasingly monitored, evaluated and their work commoditised.

From the perspective of individual adults at risk, outcomes measurement and analysis can encourage participation in devising quality indicators and in quality assurance. (See the case study evaluation undertaken by Theodosius and Hollinrake (2009)). Several participants in this present study, especially relatives, were positive about being involved and appreciated the opportunity to voice their opinions. These views need to be considered alongside the risks of contributing to potential distress when events were recalled. The value of feasibility work alongside the cognitive testing was evident in this study, on the one hand as illustrated by the recommendation to screen relatives of adults at risk to see if they had been aware of the safeguarding investigation. On the other hand, the cognitive testing suggested that an additional question could be added to the survey for participants who did not feel unsafe prior to the investigation so that this picture was encapsulated.

On the basis of the findings reported above, it was further recommended that the LA staff guidance (and the accompanying 2 page guidance support leaflet) would need to be revised to remind LA staff that they should only sample potential participants whom they judge to have the ability to participate in the survey. While this is a matter of judgement, it was suggested that the guidance should be revised to contain a section about the assessment of mental capacity in the interviewers' training. Revision of the guidance and the guidance support sheet was recommended to request that LAs alert interviewers if any of the cases sampled were particularly distressing and to provide brief details of matters that might be relevant. It was further concluded that an additional question would need to be introduced to ensure that interviewers used the past tense with relatives of adults at risk who had died.

A further consideration was that some participants expressed the wish for an opportunity to choose whether they wanted their comments about how staff could improve services to be fed back to the LA anonymously or otherwise. These suggest the potential for such surveys to have a qualitative dimension if in-depth experiences are thought to be helpful in local scrutiny of safeguarding practice. Information about anonymity also needed to be made even more explicit in documentation.

Limitations of this study:

This study relied on recruiting through LAs and this meant there were various risks of bias. On a practical level, the largest LA in this study did not always immediately update its data system when a case was closed or concluded. This process could be delayed for up to several months which could mean eligible potential participants were not recruited. The three LAs that participated in this study were volunteers and their safeguarding system may have been atypical. The decision that safeguarding staff or other practitioners would act as ‘gatekeepers’ to participants was made to minimise potential distress; the risks of them being selective were acknowledged but remain.

Conclusions

This study illustrates the complexity of survey development and the importance of cognitive testing as demonstrated here by the accumulation of significant changes needed before piloting. This study has highlighted that LA staff involved in safeguarding, adults at risk, and relatives *are* generally willing to participate in outcome data collection, but it also identified

sampling, implementation and administrative challenges which need addressing. The cognitive testing of the survey and the exploration of the feasibility of its administration proved helpful in establishing shared understandings and in identifying terminology that needed to be improved prior to pilot testing. This would appear relevant to the development of other outcome measures and quality indicators. Following cognitive testing, it was agreed that the next steps in developing the survey would be piloting and carrying out an impact assessment to establish the costs and benefits of implementing the survey

Declaration of Conflicting Interest

The Authors declare that there is no conflict of interest.

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Table 1: Total numbers of LA staff, adults at risk, relatives, carers and Independent Mental Capacity Advocates (IMCAs) interviewed (n=52) and characteristics of the sample

Interviews	Site 1	Site 2	Site 3	Total
Adult at risk	2	6	2	10
Relatives	9	3	8	20
Total	11	9	10	30
Local Authority Staff	3	3	6 (FG)	12
IMCAs (employed by five agencies)				10
Total	14	12	16	52
Sample Characteristics	Characteristics			Total (n=30)
Service User category	Older/Frailty			11
	Mental health – other			1
	Mental health – dementia			6
	Physical disability – other			4
	Physical disability – sensory impairment			2
	Learning disability			6
Abuse type	Neglect			17
	Physical harm			1
	Sexual harm			5
	Financial harm			6
	Psychological/emotional harm			1
Age (years)	18-24			6
	25-40			2
	61+			22
Sex	Male			12
	Female			18

Appendix: The evolution of the seven questions

Original Survey question	Adults at risk	Relatives/friends/carers	IMCAs	Agreed Survey wording for pilot
Stage one testing				
Q1. To what extent did you (/the person you support) feel listened to during meetings and conversations in the safeguarding investigation AND/OR when you recently met social workers about helping you feel safe?	<p>'safeguarding investigation' removed and replaced with 'feel safe' or 'concern' on all questions.</p> <p>'To what extent...' removed on all questions.</p>	<p>'safeguarding investigation' removed and replaced with 'feel safe' or 'concern' on all questions.</p> <p>'conversations and meetings', rather than 'meetings and conversations'.</p> <p>'social workers' changed to 'people'</p>	<p>Agreed with terminology changes – 'concern' and 'people'.</p>	Q1. Did you feel listened to during conversations and meetings with people about helping you (/the person you support) feel safe?
Q2. To what extent did you feel satisfied with how the safeguarding investigation was carried out AND/OR how dealing with your concern was carried out?	<p>The concept of satisfaction replaced with happiness.</p> <p>The word 'throughout' be added to the end of the question.</p>		<p>Emphasised 'throughout' needed.</p> <p>Use 'the' concern, not your concern or 'the person you support's concern' – it may not have been raised by the interviewee.</p>	Q5. How happy are you with how people dealt with the concern throughout?
Q3. To what extent were you able to understand the information given to you (/the person you support) during the safeguarding investigation AND/OR time when you had a concern?				Q3. Were you able to understand the information given to you when people were trying to help you (the person you support) stay safe?
Q4. To what extent were you given the	Question too complex.	What sources of information to		Q2. Did you (/the person you support) get

information you (/the person you support) needed at the right time during the safeguarding investigation AND/OR time you had a concern?	Examples of information needed.	be considered?		information during the concern? (This could be spoken or written)
Q5. To what extent are you (/the person you support) satisfied with outcome (what the social worker did to try and make you safer) of the safeguarding investigation ?	'Happiness' simpler than 'satisfaction'. 'Outcome' replaced with 'end result'.	Use 'end result' in place of 'outcome'.		Q4. How happy are you with the end result of what people did to try and keep you (/the person you support) safe?
Q6. Do you (/the person you support) feel that you are safer now as a result of the safeguarding investigation and the conclusion of this case AND/OR help from social workers?	What if the person is not unsafe to start with?	Question is inappropriate.		Q6. Do you (/the person you support) feel that you are safer now because of the help from people dealing with the concern?
Q6a)		Additional question added to be asked only if adult at risk has died.		Q6a. Do you feel that [the person you supported] was safer because of the help from people dealing with the concern?
Q7. Is there anything else you would like to tell us about your experience of what happened during the time we have been talking about AND/OR adult safeguarding?		Would appreciate the opportunity of giving feedback to the council.	Add ('or other organisations'). Issue of anonymity raised.	Q7. Is there anything else you think the council (or other organisations) could have done better during the time of this concern? Q7a. Would you like me to pass on your details so the council can contact you further about this? Yes <input type="checkbox"/> No, remain anonymous <input type="checkbox"/>